

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8463**

-61-034065
STATE FILE NUMBER

AMENDED

FILED SEP 21 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <i>St Louis Missouri</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St Charles</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Saint Louis</i>		Length of stay in 1b <i>1 wk.</i>	c. CITY OR TOWN <i>O'Fallon</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Luke's Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Box 320 Old Highway # 40</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>Sophia</i> Last <i>Boschert</i>			4. DATE OF DEATH Month <i>9</i> Day <i>9</i> Year <i>1961</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 20, 1896</i>	9. AGE (last birthday) <i>65</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <i>St Peters, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Frank Olendorf</i>		13b. MOTHER'S MAIDEN NAME <i>Louise Phaff</i>		14. NAME OF HUSBAND OR WIFE <i>Alfred Boschert</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Earl Boschert, Box 320 Old Highway # 40</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease with</i> DUE TO (b) <i>acute myocardial infarction.</i> DUE TO (c) <i>420.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>8-28-61</i> to <i>9-9-61</i> and last saw her/him alive on <i>9-9-61</i> Death occurred at <i>4:15 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>William A. Faughy, M.D.</i>			22b. ADDRESS <i>3720 Washington, St. Louis</i>		22c. DATE SIGNED <i>9-15-61</i>
23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-12-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St Peters Missouri</i>
24. FUNERAL DIRECTOR <i>O'Fallon Mortuary, O'Fallon Missouri</i>		ADDRESS		25. DATE RECD. BY LOCAL REG. <i>SEP 11 1961</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

NOV 16 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles J. Callahan

Licensed Embalmer No. 5128

P. O. Address O'Fallon, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.